

Elder Law



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Summer 2005

Announcement of Executive Committee Slate and Chair's Message

by Jacob H. Menashe

My year as chair of the Section is soon drawing to a close. I am glad that the year will go out with a bang. We have a tremendous CLE planned for our annual meeting CLE, scheduled for September 16th. Please read on in this newsletter for more information on the CLE and plan to attend. It's going to be great.

Our Nominations Committee has pulled together an outstanding slate of candidates for the 2005-2006 term. I will turn to that matter in a moment. But first, I want to thank our two outgoing Executive Committee members, Evelyn Zeller and Bill Hickman. Both Evelyn and Bill have served our Section with distinction and a lot of hard work.

Turning to the future, we are grateful to all who have accepted the invitation to be nominated for office and we are pleased to present to the membership the following nominees:

OFFICERS

Chair-elect:	Barbara J. Byram	Seattle
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Pursuant to the bylaws, **Eileen S. Peterson**, current Chair-elect, will serve as Chair for the 2005-2006 term and I will continue to serve on the Executive Committee as Immediate Past Chair.

As stated in the bylaws, any active member of the section may nominate other section members for a position. The nomination must be submitted in writing to William S. Hickman, Nominations Committee Chair, **no later than August 15, 2005**, by e-mail, bill@hickmanmenashe.com, or mail, Hickman Menashe PS, 4211 Alderwood Mall Blvd., Ste. 202, Lynnwood, WA 98036. To be considered, the nomination must include the name of the nominee, the position for which he or she is nominated and the written endorsement of at least three section members.

If no additional nominations are received, the individuals forwarded by the Nominations Committee will be

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SPEAK OUT!

Wanted: Lawyers to volunteer to speak to schools and community groups on a variety of topics. For more information about the WSBA speakers bureau call contact Dené Canter at 206-727-8213 or denec@wsba.org.



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This is an outline of the information that is presented to prospective clients to discuss long-term care planning as opposed to Medicaid planning. It is a revision of an article that was written for submission to a local newspaper and is meant to be a precursor to the next article by Tim Takacs which discusses the nuances of hiring a Geriatric Care Manager. The author makes no apologies for the non-technical nature of the article, as it is meant to provoke thought as to how to present the proposition of a life-care plan to a client as opposed to a Medicaid plan. Readers are welcome to submit their comments for publication in the next issue.

When I Can No Longer Take Care of Myself...

by Rajiv Nagaich

1. **Where Will I Go?**
 2. **What Will It Cost? Will I Go Broke Paying for the Care?**
 3. **Who Will Monitor My Care?**
-

As an elder law attorney, I hear these questions often. I have come to appreciate the fact that the one asking the question is likely to face the situation only once or a maximum of twice in his or her lifetime. Often I have likened the long-term care journey to a journey through the rain forest. Most have never been there, and those who try and traverse the landscape without a guide will most likely have some very nasty surprises awaiting them. A guide can, on the other hand, make the journey a more acceptable proposition.

I am frequently called by families to assist them with navigating through the long-term care maze. Most clients approach me with the questions listed at the beginning of this article. However, I have learned from experience that unless one has walked through the maze more than once, the loved one for whom we wish to provide will not be able to get the most out of the system.

As an immigrant, I came to this country believing that the streets of America were paved with gold. All I had to do was to get here on my flying carpet and pluck my little piece of the gold and I would be set. In fact, the promise has actually been close to what my life has turned out to be. I started my working life as an insurance salesman and was quite successful and content in that role until I met my wife, a native of Spokane, Washington. Here's why ...

When I first met Jamie, she was a children's therapist in Yakima, Washington. As I came to know her, I learned that her father, Bill, who had worked over forty years with the U.S. Postal Service, had been diagnosed with Alzheimer's disease in the last year of his working life. He was homebound when I first met her. I learned of the attempts Jamie's mother, Vivian, was making to keep Bill in their home. She had been told by some government agency that helps seniors (turns out to have been the Department of Social and Health Services) that there was no help available if Bill desired to stay home; Vivian would need to move Bill into a nursing home if she wanted help. After struggling to keep Bill in his home of over 20 years, for a year or two, Vivian had to give in to the financial pressures and the pressures of keeping up with the house.

She was forced to sell the family home and move into a mobile home on the river. The move was stressful for Bill, who started to wander and go back to his old house. Eventually he had to be moved into a nursing home.

As time went on, Jamie and I became close and she invited me to meet her family in Spokane. It was during that visit that I was, for the first time, exposed to life in a nursing home. It was a shocking experience to say the least. I had heard of old folks' homes as places where families left the old people to die. There are no such facilities in India, or at least there were none when I lived there. I saw all of my grandparents take their last breaths on the same pillow they had always slept on, surrounded by loved ones.

The moment I walked through the door of the nursing home, the smell alone was enough to make me want to turn around and walk back out. Inside I witnessed several people in wheelchairs, some shouting for help, though quite unsuccessfully. We went through the corridors to a room where I saw an elderly gentleman sleeping on a bed. Jamie went to him and kissed his forehead. He opened his eyes. After a brief pause, he broke into a wide grin. Jamie kissed him again and told him how happy she was to see him. He grunted an acknowledgment. I knew he was unable to speak. She then introduced me to her father. I saw no hint of recognition, only bewilderment. Bill was unshaved and smelled bad. Jamie asked for a nurse to come in and change him. We waited outside while he was being changed, then went back in and stayed for a while longer. When we were ready to leave, Jamie told Bill that we were leaving. He started to get up, and Jamie had to tell him that he could not leave. We departed quickly and asked a nurse to take care of Bill, who had said he would be okay. The workers there seemed nice enough, but there was something about all this that was not okay. Jamie broke into tears once outside the building, and we rode most of the way back to Seattle in silence. I thought, "This is not how the richest nation in the world should be treating its elders." There had to be better answers.

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This, as I now know, is quite a normal story. Bill was moved to a nursing home when Vivian was perfectly willing to take care of him at home. The system had told her she had no way to get help at home. With limited means and in no physical condition to take care of Bill herself, what else was she to do? Her children had their own lives and their own troubles. Neither Bill nor Vivian wanted to be a burden on their children.

This is not the way it has to be. Our system, for those who know how to navigate it, does allow people to remain out of nursing homes. It also permits people to access help in their own homes if that is what they desire. Sure, there are limitations to the care one can expect, but if President Ronald Reagan could spend his last days at home, why not you and I? That is the quest I undertake every time I confer with a new client. That is a quest which can be won with the assistance of a competent guide—a Geriatric Care Manager.

Though each case in my law firm could start and end with me addressing the laws surrounding the question of how to safeguard a client's wealth so that it is not squandered on nursing home costs or grabbed by the Medicaid system when all is said and done, I do not start or end there. The point of doing planning with my clients is to make sure that we are able to rule out every other option before settling on a nursing home stay. The first question then becomes: "What is the least restrictive environment the client can live in safely?" Recognizing that one's home is usually the least restrictive environment and that a hospital is the most restrictive (with independent living facilities, assisted living facilities, adult family homes, and boarding homes in between in order of hierarchy from least restrictive to most restrictive), why not start by getting an assessment of the mental and physical condition of the client to determine whether or not the client can safely stay at home, and if so, what changes or alterations are necessary in order to prevent innocent accidents (slips and falls, etc.) that could land the person in the hospital and away from home? As I am neither educated nor trained nor experienced to make that determination, I seek the assistance of a Geriatric Care Manager (hereafter GMC) to make that call.

There is another reason to get the GCM involved in each case early on: to maximize the benefits available under COPEs if a family decides that a nursing home is not the place in which they wish to place their loved one. In our society, many people who are not working due to retirement or disability do not have a regular means of income. They also do not have a regular medical insurance policy to cover them. Under those circumstances, our government provides them income through the Social Security system (provided they qualify) and health coverage through one of many federal- and or state-funded programs. For

most of my clients, that federal program for health coverage is the Medicaid system. It is the measure of last resort, and one that most of my clients have to accept.

Why is that when Medicare is there to cover the medical bills? Well, Medicare is a program that draws a clear line in the sand. All medical conditions that fall on one side of the line are fully covered (subject to deductibles and co-pays, which may be covered by a supplemental policy if one has such a policy), and all conditions on the other side are not covered. What is covered is acute care. If one has a heart attack, cancer, broken hip, diabetes, or any other condition for which the doctor can prescribe a pill or perform an operation and if there is a chance of the person getting better, medical care is usually covered. But if one has Alzheimer's, Parkinson's, dementia, or another disease which robs the individual of his or her ability to manage the activities of daily living without assistance, those needs are considered to be chronic care needs and are not covered. How can that be, when all of these are medical conditions? Because that is what the law states. If one has a condition from which he cannot get better, that condition is not covered and the only place he can get any coverage is through the Medicaid system.

Once we understand that Medicare will not cover chronic care and we accept that Medicaid is the only game for most seniors and disabled people, the obvious question becomes "How do I qualify?" The answer to that question is that the individual seeking the benefits (hereafter the applicant) under Medicaid must meet the following three qualifications:

1. Undergo an assessment which proves that the applicant's condition warrants intervention either by way of a nursing home stay or by means of assistance to be brought into the home or to be provided in an assisted living facility, adult family home, or a boarding home (more on this below).
2. Have an income that is less than the average private pay rate in a nursing home (\$181 per day as of the writing of this article) or income of no more than \$1,737 a month if the applicant desires to stay out of a nursing home (more on that below).
3. Have no more than \$2,000 in assets (bank accounts, interest in a house, car, etc.). In addition to the \$2,000, the applicant is allowed to own one automobile worth \$5,000 or less; a prepaid, but irrevocable, funeral plan of reasonable value or \$1,500 in a bank set aside as funds for final expenses; \$1,500 in cash value in a life insurance policy (if the total face amount of all life insurance policies does not exceed \$1,500); burial plots for all family members; and all of his personal prop-

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erty. If one meets those qualifications, one can apply for Medicaid.

The resources allowed a married applicant are a bit more generous. The spouse of a married couple is allowed to keep between \$40,000 and \$95,100 in assets other than a house and one car of any value. The spouse can also have \$1,500 set aside for funeral expenses or have a prepaid, but irrevocable, funeral plan.

I hope that readers have gotten the idea that if any client of mine expresses a desire to stay out of a nursing home, that is what I will help the family do first. However, that is easier said than done. Staying away from a nursing home and yet qualifying for Medicaid benefits first means that the applicant's income must be below \$1,737 per month (unless the applicant can be qualified on a limited exception waiver program that has severe limits and is practically unavailable to married applicants). Additionally, for a married applicant, the spouse is allowed to keep \$40,000 in resources and no more.

If an applicant is able to meet the income and resource test, usually the next hurdle is subjecting the applicant to an interrogation by a Department of Social and Health Services social worker, who will ask several questions using CARE (Comprehensive Assessment Reporting Evaluation tool). CARE is a recent phenomenon in Washington. It is the state's way of making sure that the benefits are not being abused. The answers to questions are rated on a scale. The rating is quite subjective and varies from social worker to social worker. There is no avoiding that fact. In practical terms, what I have seen happen in many cases is that the social worker asks the applicant questions like "How do you feel? Are you able to walk around the room? Are you able to take a bath? Are you able to go to the toilet by yourself?" Most applicants will put their best faces forward in front of a stranger, which means that the social worker will score the needs lower than what they actually may be. Once the answers are fed into the computer, a report is generated using a fairly complex algorithm which determines the number of hours of paid assistance to which the applicant is entitled. That assessment can be challenged—an expensive and time-consuming affair. I find it beneficial to have a GCM conduct a similar assessment before the social worker arrives and to get the applicant's physician, family members, and facility to agree on the applicant's needs. Next, instead of having the social worker interview the client, I have the social worker meet with the client and the GCM, who can make sure that the questions are answered properly. I find that it is the only way to avoid challenges and make sure that the applicant gets the maximum number of hours of paid care to which he is entitled under law.

That assessment is only the beginning. The GCM is then charged with the task of developing a care plan for family members to follow and of making sure that it is implemented. The GCM can be consulted as often as needed and also can be the one who regularly monitors the care the applicant is getting. Once the state awards the paid hours, the next issue is coordinating the care. This means not just getting a neighbor to provide the care (though sometimes that may be more desirable than hiring a professional company), but finding a reputable and stable company with a track record of providing proper care. It also involves ordering the appropriate durable medical equipment and sometimes foregoing the Medicaid- and Medicare-paid equipment in favor of moderately priced equipment better suited for the applicant. Finally, it requires following up on the care the applicant is receiving.

Let me put the above reasoning into an example. Recently, Vivian, my mother-in-law, was diagnosed with kidney cancer. She was having difficulty walking, and it was quite by accident that the primary care physician caught the mass in a bone x-ray. Off she went to the hospital. She fell outside the hospital and broke her femur. My wife and our one-year-old son were with her at the time. I was at the office, knee deep with appointments and work. My wife called hysterically on the phone. I left work in the middle of the day to meet her at Virginia Mason, where I spent most of the afternoon meeting with doctors and trying to understand the situation. Once I came to grips with the fact that Vivian would undergo surgery and be in the hospital for a few days, I called a GCM to meet us at the hospital. She came and was introduced to the staff. She reviewed the medication regimen with the staff and left instructions that she would be coordinating the discharge. The hospital did not understand why we were paying for services that they normally perform for free. My reasoning was that I did not want Vivian to be discharged to just any nursing home. I wanted her to be in the best one available, close to home, and with instructions to allow her to return home as soon as possible. Vivian has been living with us for over nine years now. The hospital made an attempt to discharge her to a nursing home that I would not want anyone to go into. The GCM was there to make sure that did not happen. We did not get to take Vivian to our number one choice as it was full, but were able to get her into one within walking distance from our home. It is a very nice facility. Knowing that it is not the facility that makes a difference, but the staff, we made sure the GCM understood what medications Vivian would be on and what therapy she would need, and the GCM met with the social worker to make sure that there were no mistakes. Vivian was taken to the nursing home. As a bonus, the

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GCM requested a private room, if available, even though Medicare would be paying the bill. The nursing home honored the request and after two days placed Vivian in a private room. All the durable medical equipment was there. My wife and I did not have to worry about organizing the discharge and making Vivian comfortable in the nursing home; we knew that those things would be taken care of and we would be free to just fuss over her once she was there. The GCM kept us abreast of what was going on every step of the way. Finally, when Vivian was discharged to our home, the GCM arranged for a catalog to be given us so we could decide whether or not to accept the Medicare-paid equipment. One look at the options and we decided to pay privately for her walker, wheelchair, and hospital bed. What a difference that has made! Vivian does not have the walker with two wheels and tennis balls on the other two legs that would never allow her to walk around the block. She got one with four wheels, with brakes and a seat. Vivian walked around the block within the first two days she was home. There is a similar story about the bathroom stool, the point being that with a guide we were able to walk through this part of the jungle with little worry. Jamie was able to concentrate on our family and make time for her mother at the same time.

Isn't that the advice that each of my clients comes to me for? They want to save money so that they can use it to better the lives of their loved ones. They want answers to their many questions: Once the money has been saved, how do they use it? Is it being used in the best way? Is there a better way? Hiring a GCM answers the question of how to use the money to enhance the quality of life for the Medicaid recipient so that the recipient can have the best possible life and the family members can have peace of mind knowing that they are not alone in trying to figure it all out. And I, as the attorney, can have peace of mind knowing that the Medicaid recipient can continue to have the dignity that each one of us should have through the very last days of our lives. That knowledge fuels my fire to do it again and again.

I hope that I have been able to make the case for every elder law attorney taking a close look at the issue of hiring a Geriatric Care Manager. The article beginning on page 4 is written by Tim Takacs, my personal hero, who discusses how to go about it.

MARK YOUR CALENDAR NOW

SEPTEMBER 16

ANNUAL ELDER LAW CONFERENCE

THE CUTTING EDGE OF ELDER LAW

Featuring Keynote Speaker

William H. Colby

*"From Cruzan to Schiavo:
What Have We Learned?"*

Nationally recognized author William H. Colby headlines this year's Conference. Mr. Colby represented the Nancy Cruzan family. He is a recipient of the Bioethics Vision to Action Award and a Fellow for the Center for Practical Bioethics (Kansas City). He has appeared on the NBC Today Show, Hardball with Chris Matthews, ABC World News Tonight with Peter Jennings, Larry King Live, and CBS This Morning, among others. His publications include *Unplugged: Reclaiming Our Right to Die in America*, AMACOM Publishing (May 2006) and *Long Goodbye: The Deaths of Nancy Cruzan*, Hay House (October 2002). He has appeared before various state bar or hospice association annual meetings, colleges, law and medical schools.

Additional Program Highlights

Earn Ethics Credits:

Elder Law Attorneys and the Rules of Professional Conduct: Critical Cautions

Vulnerable Adults:

Financial Exploitation, Predatory Practices and Remedies

Updates:

COPES; Medicaid; Case Law; New Legislation

Doubletree Hotel Seattle Airport
18740 Pacific Highway South, Seattle, WA

For further information, see:
<http://www.wsba.org/cle/default.htm>

Getting Started in Life Care Planning

by Tim Takacs¹

"I need to come in right away," Susan told one of our geriatric care managers who took her call. Her mother has cerebral palsy and her father, who had been caring for her mother in their home, had a stroke and was undergoing rehabilitation at the hospital. Susan had hired round-the-clock caregivers for her mother and it was costing a fortune. She didn't think the money would last for very long and she did not know what to do. Should her parents live with her? Susan had investigated putting an elevator into her own home and bringing Mom and Dad there.

"What should I do with my parents' home?" she asked. "What if my dad doesn't get well enough to look after Mom again? How can I afford the caregivers to take care of Mom and a nursing home for Dad?" A successful local bankruptcy attorney, Susan really felt the need to get things planned out. She had 50 million questions running around in her head and was searching for the answer to each one. Our GCM scheduled a first meeting for Susan, who came in and hired us for a Life Care Plan on behalf of her parents.

Still, Susan was worrying about getting answers to all her questions. Anxious and frustrated, she called our geriatric care manager about her dad's progress in the rehab hospital. What was the next step? What should she do if he goes back home? How long could he afford to stay in the nursing home? Again 50 million unknowns.

Our GCM told her the only thing she needed to concentrate on today was making sure her dad got to the skilled nursing facility to continue his therapy. The nursing home was close to their home. If he had to stay there it was convenient; the facility took Medicaid if the couple needed it; and we know the people at the nursing home. They have a reputation for providing good care and taking care of our clients.

That was Susan's next step, our geriatric care manager counseled her, and the only thing she needed to get done. All the other scenarios would play out during the weeks and months ahead—if they ever came to pass at all. Frank and Edith had enough money to last for years and pay for everything. Later, at our next meeting, Susan remarked, "Hiring you guys was worth every penny. Just the peace of mind you have given me. Letting me know I only had one job for now and that was getting my dad in that nursing home and I didn't have to try and plan months in advance. You've made all the difference in the world for me."

An Opportunity for Elder Law Attorneys

Frank and Edith are two of an estimated 99 million Americans for whom chronic conditions are a fact of life. Of these, 41 million people have their daily activities limited in some way because of their condition, and 12 million are unable to live independently.² Many of these Americans are "elderly"—people who are 65 and older. Regrettably,

as people age, they must prepare for the likelihood of future impairment and their need for long-term care. Loss in a person's ability to function day-to-day is a natural part of the aging process, and those losses become more severe as people get older. Of the one out of five elders who have attained age 85, more than half are impaired and need long-term care—that is, the personal assistance that enables them to perform daily routines such as eating, bathing, and dressing.³

The prevalence of physical and mental disability among the elderly is growing rapidly along with America's aging population. The number of Americans who will suffer functional disability due to arthritis, stroke, diabetes, coronary artery disease, cancer, or cognitive impairment is expected to increase at least 300 percent by 2049.⁴ The challenge for our society is how we are going to manage the care of these increasing numbers of disabled elderly persons.

How do elders with chronic conditions obtain care and manage their illnesses today? About 85 percent of elders who need long-term care receive it from family and friends; few receive assistance from paid professionals or aides because of quality or financial concerns.⁵ Caregivers perform complex medical tasks, including medication administration, and errors can result. Shirley Loflin, a caregiver whose writing appears on the Web site of the Rosalynn Carter Institute for Caregiving, writes: "Caring for another's every need, making life or death decisions, being on call 24/7 and dealing with many unknowns is a tough, demanding, and in some instances, an isolated, thankless job."⁶ Caregiving is now viewed as an unpaid extension of the public health system, providing approximately \$196 billion in uncompensated care annually.⁷ What can be done to support caregivers? For elders with ineffective or insufficient caregiver support, what can be done to prolong their independence?

In its Quality Chasm Report, the Institute of Medicine has called for a transformation of the U.S. healthcare delivery system to correct the deficiencies in the current management of persons who suffer from these chronic illnesses.⁸

These deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

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Why is care for chronic conditions so deficient? The Quality Chasm Report attributes the quality gap to (1) the increased demands on medical care from the rapid increases in chronic disease prevalence and the complexity of the underlying science and technology; and (2) the inability of the system to meet these demands because of our poorly organized delivery system and constraints in using modern information technology.

Many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of these illnesses. Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive—responding mainly when a person is sick—to one that is proactive and focused on keeping a person as healthy as possible.⁹

In defining six aims for transforming healthcare in America, the Institute of Medicine Quality Chasm Report declared patient-centeredness a central feature of quality, along with safety, promptness, effectiveness, efficiency, and equity.

Historically, patient-centeredness has been perceived as the assessment of needs and preferences to consider those social and cultural factors which affect the clinical encounter or compliance with treatment. A consensus is growing among healthcare providers, however, that patients have a more active role to play in defining and reforming healthcare, particularly in chronic disease management, where patients provide the majority of care in day-to-day management of their illness. According to the Improving Chronic Illness Care program, “patient-centeredness may be a first principle that can provide a lens to focus action, and as such can be used as the guide for achieving all six aims.”¹⁰

With support from the Robert Wood Johnson Foundation, the Center for Health Studies has developed the Chronic Care Model¹¹—a guide to chronic care improvement—that is useful to diverse health care organizations wanting to improve the care of their patients with chronic illness. Critical to improving chronic care outcomes is engaging the “informed, activated patient” to promote better self-management of chronic illness. Unfortunately, as the Center’s director Dr. Edward Wagner admitted last summer at a conference at the University of Washington, patient education, which is a necessary component of the Model, is nearly non-existent.¹²

Seeking the Elder-Centered Law Practice

Fifteen years ago I decided to devote my professional life to being an elder law attorney. Like many of you, I am sure, I began by learning at the feet of other elder law attorneys. What I learned was that elder law was really synonymous with Medicaid planning, and that after I tried

out this asset-focused practice for awhile I was not satisfied with the answers or, better, non-answers I was unable to give to our families who had questions about the long-term care system that they were thrust into and didn’t know how to make their way through.

Our families had questions I could not answer: The skilled nursing facility is telling us that Momma needs this therapy and not that one—what does that mean and which one should we choose? How do we talk to the doctor and the therapist about what is wrong with Daddy? What are Dad’s residential options now that his health has improved but he can’t return home? How do we take care of Mom during the day while both of us work? My husband has been diagnosed with X, Y, and Z—what are the likely outcomes for him? As his wife, what can and should I do for him? Can I take care of him at home? What support services are available to me?

These aren’t legal questions, but as an elder law attorney who aspired to the “holistic” approach I needed to do better than reply, “I can’t help you with those questions...but I can help you save the money from the nursing home.”

I realized that to change my elder law practice I had to change the way I thought about the practice of elder law. Instead of Medicaid planning, I began to think about my practice as planning for disability, and then, finally, as “life care planning.”

I began to learn more and more about aging and long-term care and what in our office we call the “elder care continuum.” In our office, we think about the elder care continuum as a timeline on which our client-elder is moving toward the end of his life. The ideal for all of us is to “age in place.” That invariably means the elder who lives in his own home, independently and successfully with no assistance needed, until he keels over dead in his living room or in his bed.

Some people have the good fortune to depart this life in this manner, but many do not. Instead, they may have Alzheimer’s or Parkinson’s disease, or suffered a disabling stroke, or become frail, or otherwise have found themselves moving down the elder care continuum. They find that they need assistance with activities of daily living. That means they need to plan for their long-term care needs.

What does life care, or long-term care, planning mean? I describe long-term care planning as our discovering the client-elder’s place on the elder care continuum and then figuring out what we need to do to identify, access, and pay for good care for the client, both now and in the future. That is not as easy as it sounds, but for an elder-centered practice, it is the essence of what we do.¹³ Our clients need

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to get good care when and where they need it, and they need to know how to pay for it. They need to be the “informed, activated patient”—the necessary partner with the health care community that will make the Chronic Care Model work.

Here is our opportunity as elder law attorneys. Attaining this objective for our clients requires expanding an elder law practice beyond the traditional, narrow Medicaid focus. I call this type of elder law practice the “care management” model.

An Integrated Approach to Long-Term Care Planning

The issue that typically brings many elders and their families into the elder law attorney’s office is financing the cost of nursing home care. Despite their concerns about saving money, however, almost without exception the families who come to the Elder Law Practice tell us that their primary goal is to promote the good health, safety, and well-being of their loved one, whether she is at home or already in a nursing home.

To be honest, they don’t put it quite that way. They tell us: We want to take care of Mom. They just don’t know how to do that. They have experienced firsthand the deficiencies in care described in the Quality Chasm Report. Like Susan, our clients’ daughter, discovered once she and her parents found themselves in the long-term care system, our families don’t know what to do. Who can they turn to for help in taking care of their loved ones?

Some elder law attorneys have described working with elderly clients and their families as “life planning,” rather than as attaining a specific goal, such as attaining Medicaid eligibility. On this theme, at the 2002 NAELA Institute in Albuquerque, New Mexico, I gave a presentation on the “Life Care Plan.” As articulated in our Life Care Plan, our philosophy at the Elder Law Practice elevates client quality of life and care above all other goals of the planning process.¹⁴ Apparently, my presentation and subsequent articles I’ve written about life care planning have resonated with many elder law attorneys who have become dissatisfied with the emphasis on Medicaid asset protection that dominates the practice of elder law today.

As Medicaid spending continues to grow¹⁵ and the states and the federal government further restrict eligibility and services, I believe that the future of elder law lies with transforming the practice from Medicaid planning to the true integrated approach to which the National Academy of Elder Law Attorneys has been aspiring since the organization was founded in 1988:

Under this holistic approach [says NAELA], the elder law practitioner handles general estate planning issues and counsels clients about planning for incapacity with alternative decision-making

documents. The attorney would also assist the client in planning for possible long-term care needs, including nursing home care. Locating the appropriate type of care, coordinating private and public resources to finance the cost of care, and working to ensure the client’s right to quality care are all part of the elder law practice.¹⁶

Not many elder law attorneys include as a part of their fee-generating services “locating the appropriate type of care” and advocating—and intervening, if necessary—to “ensure the client’s right to quality care.” Few elder law attorneys are equipped by virtue of education and experience to ascertain what long-term care is appropriate, know what long-term care services are available in their communities, recognize deficiencies in long-term care, and understand how to advocate for good long-term care.

Finding and Hiring Your Geriatric Care Manager

We elder law attorneys cannot do this type of planning ourselves. To become experts in long-term care planning, we need to hire persons who specialize in long-term care for the elderly. To us, that person goes by the title “geriatric care manager.” In your community, and mine, this person could be a registered nurse working in a home healthcare agency, an administrator of an assisted-living facility, a long-term care ombudsman, a hospital discharge planner, or a social worker at the VA skilled nursing facility—in short, anyone who has the education, experience, and passion to serve elderly persons who need long-term care and who is able to work independently to help clients and their families access resources and solve healthcare and long-term care problems.

Making the decision to hire and then hiring the right person to be your geriatric care manager (GCM) is what I call a “leap of faith.” Seven years ago I hired my first GCM. Joanne Bass walked into my office on a sales call as director of Kelly Assisted Living in Nashville, and when she left, she and I had agreed that we would talk more about how she would be a geriatric care manager in my elder law practice. Before I hired her as an employee, Joanne and I had several conversations about this very subject. Would she be contract labor or would she be an employee? Would she bill separately for her services or would her services be integrated within the total package of services that we would offer to our clients?

To take my practice in the direction I wanted to go, towards an integrated approach to meeting the long-term care needs of our clients, I realized that to refer clients to GCMs or to bill clients separately for our firm’s geriatric care management services was not going to work. If the

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GCM were not an employee, I would have no control over how and when or even whether those services are provided. As Washington elder law attorney Rajiv Nagaich wrote in his email message asking me to write this article: "From a personal standpoint, I have been working with two GCMs on a contract basis, but their absence from my office makes for a difficult partnership." If the GCM were an employee who bills the client separately for her services, especially if billed hourly, I foresaw that few clients would appreciate their value and would decline to utilize those services.

You will find as you go down this road that you will be tempted to refer the work out to a freelance GCM. Do not succumb to this temptation. Otherwise, when your clients come to your office, you will still be just a Medicaid planner and "care management" consists of your telling your clients to retain the freelance GCM to answer those other questions you and your firm cannot answer. In my experience, you must make a financial commitment to move yourself to a care management model of elder law practice. That's the leap of faith—care management costs *you* money—that will provide the initial motivation to make this model of practice work for you.

If you are already making money in a Medicaid planning practice, you have an advantage of a built-in clientele as well as a steady stream of continuing work for your GCM (not to mention the financial wherewithal to hire a GCM). My sense of the landscape, however, is that it is not the financially comfortable Medicaid planners who are looking to change their practice to care management. Rather, it is the attorney newer to elder law without a large, established client base or presence in the community who sees this as an opportunity.

If you are among the latter, and not the former, take heart. In 1998, when I hired Joanne Bass as my first GCM, she was my second employee. My first employee, Lisa Love, was (and is) my office manager and legal assistant. Joanne started out working three days a week, but if she had been full time, her salary would have been about the same as what I was taking home. Although by then most of what I was doing was "elder law," which I defined as Medicaid planning and estate planning (wills and powers of attorney), I was by no means making a fortune in elder law practice.

In 1999 I hired a Medicare specialist who also does the firm's marketing and public relations. At her choice, Bonnie worked, and still works, three days a week. Since 2000, I have added three full-time GCMs, three office assistants, another attorney (Julia Merkt), and opened another office in Gordonsville, Tennessee, staffed by Julia, Joanne, and an office assistant.

In 1998, Joanne's first year with the Elder Law Practice, my fee income from elder law cases doubled. In 1999, my

fee income from elder law cases was twice what it was in 1998. In other words, by the end of 1999, my fee income from elder law cases was four times what it was in 1997. Every year since 1997 we've enjoyed large increases in fee income.

My purpose is not to brag about how well we are doing financially, but to show you what you might expect if you, too, make the leap of faith. Although financially I am doing well, remember, it costs a lot of money to do care management, so not all of this fee income goes directly into my pocket. But when Medicaid "goes away," as many NAELA members fear, the Medicaid planners in NAELA will have nothing to do. Nonetheless, people will still get older and will still need long-term care. And the Elder Law Practice will be here to help them find, get, and pay for good long-term care.

What Do Our Geriatric Care Managers Do?

We are very aggressive when it comes to letting the world know what we do in our care management model of elder law practice. When Joanne Bass first hired on, there were many days that I never saw her, when she never came in to the office at all. What she did for most of her first six months was to call on her contacts in the healthcare and long-term care community and let them know where she was now, and what we are doing at the Elder Law Practice.

What you will find when you hire your first geriatric care manager and get her out in the long-term care community is that the image that community has of you will not be as of a "Medicaid planner" but as an organization that has the same goal as they do: to promote the good health, safety, and well-being of their resident or patient and your client. When our GCMs visit our clients at nursing homes, assisted living facilities, or wherever they happen to be—and among our four GCMs at least one of them is out of the office nearly everyday—the facility knows that we are all in the same business: helping our families take care of someone's mother, or father, or spouse, or other loved one. That's a powerful message your firm is projecting within the community.

The Elder Law Practice is a part of this long-term care community. Because that community knows we are serious about the number one goal of the Life Care Plan—to promote the good health, safety, and well-being of our client at all times—we get results when it is necessary for us to advocate and intervene on behalf of a client who is not getting good care.

A client had recently completed his therapy in the skilled nursing facility after suffering a stroke, which affected his ability to feed himself and take food and water by mouth. When his wife and daughters first came into our

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office, they reported to us that he had been losing weight. His food trays were returned to the kitchen almost untouched, even though the family claimed he retained his appetite. At the nursing home, he was labeled a "feeder." We were concerned that the facility had written him off. Our GCM paid a visit to the facility's director of nursing and "reminded" her that we are watching out for him. The staff spent more time with him at meals, he gained weight, and his general health has improved.

Fortunately, few of our interventions are literally as life-saving as we perceived this one to be. Everyday, though, our GCMs are working with our clients and their families to improve the lives of our clients.

As a part of their Life Care Plan, one of our geriatric care managers is assigned to help our clients and their families with their long-term care concerns. At the Elder Law Practice, the client's GCM functions as the point of contact for the family and assists in coordinating services to help families take care of their loved ones.

Here are some things our geriatric care managers do: The GCM who is assigned to a client will conduct a care assessment in the client's home to identify care and related problems and assist in solving them. That might include arranging in-home help or other services. Our GCMs have extensive knowledge about the costs, quality, and availability of resources in the community. Often, as a result of an in-home assessment, we will recommend that sitter services be put in place and provide the family with a list of providers, and, if necessary, actually help with the making of arrangements for care in the home.

Our GCMs do not provide healthcare, long-term care, or companion services to our clients. Otherwise, we would risk being classified as healthcare providers and therefore subject to state licensing requirements. Our fee agreement for the Life Care Plan explicitly excludes these services.¹⁷

The GCM will coordinate healthcare and long-term care providers. Recently, one of our cases began with reports from the wife, who had suffered a stroke a few months before, that her husband, who has end-stage renal disease, was suffering delusions and becoming aggressive. It was becoming more difficult for her and her family to meet his needs at home. After an in-home assessment of him, our GCM contacted several healthcare facilities about arranging an evaluation to determine whether or not he was suitable for inpatient services. He was evaluated and admitted to the hospital, and his medications were adjusted and monitored.

While the family was undergoing this crisis, our GCM was talking regularly with the facility in order to identify the most appropriate placement for our client following discharge. His medical and long-term care needs dictated that he could no longer live at home, and he went to a residential facility. We then helped him apply for and

obtain public benefits to pay for his care. Meanwhile, we will monitor the long-term care needs of his wife, also our client, who is still living at home. And we do all of this for one fee, which is paid at the outset of the representation.

Of course, for this family it was the healthcare crises that both spouses were suffering that brought them into our office in the first place. They did not know what to do. Plainly, their problems were not just "how do we pay the nursing home."

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² Institute for Health & Aging: University of California, San Francisco, "Chronic Care in America: A 21st Century Challenge," 1996.

³ Congressional Budget Office, "Financing Long-Term Care for the Elderly," April 2004.

⁴ See National Center for Health Statistics, "Tables on Trends in Health and Aging," <http://209.217.72.34/aging>; C. Boulton, M. Altmann, D. Gilbertson, et al., "Decreasing disability in the 21st century: the future effects of controlling six fatal and nonfatal conditions," *Am J Public Health* 1996;86(10):1388-93, cited by AHRQ Research in Action, "Preventing Disability in the Elderly with Chronic Disease," April 2002.

⁵ K. Donelan, et al., "Challenged To Care: Informal Caregivers In A Changing Health System," *Health Affairs*, July/August 2002.

⁶ See Shirley Loflin, "The Face of Caregiving," <http://rci.gsw.edu/shirleyloflinindex.htm>.

⁷ *Toward a National Caregiving Agenda: Empowering Family Caregivers in America 2*, National Alliance for Caregiving, July 2001.

⁸ *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, March 2001.

⁹ See Improving Chronic Illness Care (ICIC) program of the Robert Wood Johnson Foundation, <http://www.improvingchroniccare.org>.

¹⁰ Improving Chronic Illness Care, <http://www.improvingchroniccare.org/tools/pac.htm>.

¹¹ See <http://www.improvingchroniccare.org> for a description of the Chronic Care Model, developed by Dr. Edward H. Wagner at the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative, and leader of ICIC; and E. H. Wagner, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs*, Nov/Dec 2001.

¹² "Improving Care of the Chronically Ill," 2004 Epidemiology, Biostatistics and Clinical Research Methods Summer Session co-sponsored by the Seattle Veterans Affairs Epidemiologic Research and Information Center (ERIC) and the University of Washington; <http://researchchannel.org/program/displayevent.asp?rid=2390>.

¹³ For a presentation on life care planning at *Special Needs Trust VI*, the seminar produced annually by the Stetson University College of Law, I said that I define what I do in 12 words, all of one syllable: "I help folks find, get, and pay for good long-term care."

¹⁴ See Timothy L. Takacs, "The Life Care Plan: Integrating a Healthcare-Focused Approach to Meeting the Needs of Your Clients and Families Into Your Elder Law Practice," *NAELA Quarterly*, Winter 2003; and "The Life Care Plan," *The Elder Law Report*, February 2004.

¹⁵ National Governors Association, "The Fiscal Survey of States," December 2004.

¹⁶ From "What Is Elder Law?," NAELA Web site, at <http://www.naela.org/public/whatisEL.htm>.

¹⁷ See our Web site at <http://www.tn-elderlaw.com/lifecare.html>. From this page you can download a specimen of our fee agreement.

Practice Tips – Estate Planning and IRAs

by Doug Legg – Investment Representative – Edward Jones Trust Company

Part II - REQUIRED MINIMUM DISTRIBUTIONS

This outline is intended solely for use by attorneys and other estate planning professionals and is provided to facilitate discussion regarding certain estate planning and tax planning issues. It is not intended to be legal advice and should not be treated as such. Neither Edward Jones nor Edward Jones Trust Company assumes any responsibility for any person's reliance upon the information contained herein. Each person in receipt of this outline should independently confirm any information contained in the outline and should independently determine the applicability of any of the estate planning or tax planning concepts contained herein to any particular situation in which they may be involved.

Importance. Individual Retirement Accounts (IRAs) have become an increasingly popular retirement planning tool and the value of assets held within such accounts continues to grow. Before clients pass away, it is important to plan for the ultimate distribution of the remaining balances of these accounts to the clients' intended beneficiaries. Consequently, it is critical to understand the implications of the different beneficiary designation options available to the client.

This topic will be explored in two parts: Part I covered the nuances of actually selecting a beneficiary, whether it be an individual, several individuals, a charity or a trust. Part II covers Minimum Required Distribution rules for both the account holder and the beneficiaries upon the death of the account holder

REQUIRED MINIMUM DISTRIBUTIONS

- A. **Introduction.** As the name implies, the RMD rules govern the minimum amount of distributions required annually from an IRA both before and after the Client's death. The Client, or the beneficiary(ies) after the Client's death, always has the ability to take distributions larger than the RMD from the IRA, including a distribution of the entire account. However, because of the tax deferral benefits of IRAs, many Clients and/or beneficiaries prefer to have the opportunity to take the smallest possible amount of distributions from the IRA. Application of the RMD rules following the death of the Client may be affected by the Client's beneficiary selection. Consequently, an understanding of the RMD rules is necessary to select the appropriate beneficiary.
- B. **New Regulations.** The IRS issued proposed regulations in 2001 that greatly simplified and generally improved the RMD rules. The final regulations were promulgated in April 2002 and generally allow for smaller required distributions than under the prior rules. See Reg. § 1.401(a)(9)-0 through Reg. § 1.401(a)(9)-9.

C. **RMD Calculations Before Client's Death.** The Client must begin receiving distributions from their IRA no later than the required beginning date ("RBD"). IRC § 401(a)(9)(A).

1. **Required Beginning Date.** The RBD is April 1 of the year following the year in which the Client attains the age of 70-1/2. IRC § 401(a)(9)(C)(i)(I). Although the Client has until the RBD to receive their first RMD, the Client must receive their RMDs for all successive years by December 31st of each year. Reg. § 1.401(a)(9)-5, Q&A-1(c).

2. **Applicable Divisor.** The Client's RMD is calculated by dividing the Client's account balance as of December 31st of the prior year by a life expectancy factor, or "applicable divisor," for the Client. Reg. § 1.401(a)(9)-5, Q&A-1(a). The applicable divisor can be found in one of two tables published by the Internal Revenue Service. One table is for Clients who have selected their spouse as the sole beneficiary and that spouse is more than ten years younger than the Client. *Joint and Last Survivor Table* at Reg. § 1.401(a)(9)-9, Q&A-3. All other Clients will refer to the more commonly used *Uniform Lifetime Table* at Reg. § 1.401(a)(9)-9, Q&A-2.

3. **Example.** Single Client attains the age of 70 _ years in 2004. Her first RMD will be for 2004. Her RBD is April 1, 2005, so her 2004 RMD must be distributed by that time. The RMD will be calculated by dividing the IRA value as of December 31, 2003 by the applicable divisor found in the Uniform Lifetime Table. Her RMD for 2005 must be paid by December 31, 2005 and will be calculated using the IRA value as of December 31, 2004.

D. **RMD Calculations Following Death of Client.** Following the death of the Client, required distributions will be based on (1) the identity of the beneficiary (spouse, non-spouse, trust, etc.) and the qualification

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of that beneficiary(ies) as a “Designated Beneficiary” and (2) whether the Client dies before or after the RBD. Designated Beneficiaries will use the *Single Life Table* at Reg. § 1.401(a)(9)-9, Q&A-1 to calculate RMDs.

1. **Designated Beneficiary.** A Designated Beneficiary is an individual or a “qualifying trust.” Reg. § 1.401(a)(9)-4, Q&A-1; Reg. § 1.401(a)(9)-4, Q&A-5. A qualifying trust is defined and discussed later in this outline. Neither an estate nor a charity can be a Designated Beneficiary.
2. **Designation Date.** Determination of the identity of the beneficiary and determination of its status as a Designated Beneficiary does not need to be finalized until September 30th of the year following the year of the Client’s death (“Designation Date”). Reg. § 1.401(a)(9)-4, Q&A-4.

The period of time before the Designation Date may provide a valuable opportunity to allow for post-mortem planning by the beneficiary(ies) and the Planner. In situations with multiple beneficiaries, distributions may be used to satisfy or eliminate a certain beneficiary(ies) that cannot qualify as a Designated Beneficiary(ies). This would allow the remaining beneficiary(ies) to qualify as a Designated Beneficiary(ies) and benefit from further deferral opportunities. Additionally, estate-planning techniques such as the disclaimer may be used during this time to provide for a more tax efficient distribution of the IRA. If a trust is named as beneficiary, this period of time may also provide an opportunity for the trustee to use distributions or estate planning techniques to allow the trust to become a “qualifying trust.”

3. **RMD Calculation Following Death of Client When Death Was Before Client’s RBD**
 - a. **Beneficiary is Not a Designated Beneficiary.** If the beneficiary is not a “Designated Beneficiary,” the balance of the IRA account must be completely distributed before December 31st of the year of the fifth anniversary of the Client’s death (“the 5-year rule”) Reg. § 1.401(a)(9)-3, Q&A-2 and Q&A-4.
 - b. **Non-Spouse Designated Beneficiary.** If the beneficiary is a Designated Beneficiary, the balance of the IRA can also be distributed through RMDs calculated using their life expectancy (“life expectancy payout”). Reg. § 1.401(a)(9)-3, Q&A-1. If the Client has selected that option, RMDs must

begin by December 31st of the year following the year of the Client’s death. Reg. § 1.401(a)(9)-3, Q&A-3(a). If the Designated Beneficiary fails to receive their RMD by that time, the entire IRA balance must be distributed under the general 5-year rule.

Example. Client named his daughter as the beneficiary of his IRA before dying in 2004 at the age of 66. Daughter may choose the 5-year rule and receive a distribution of the entire IRA balance by December 31, 2009. Daughter may also choose the life expectancy payout by taking her first distribution by December 31, 2005. The RMD would be calculated by dividing the balance of the IRA as of December 31, 2004 by the applicable divisor for Daughter’s age found in the Single Life Table.

- c. **Spouse as Designated Beneficiary.** If the Client has selected their spouse as the Designated Beneficiary, the spouse may choose to begin distributions from the IRA by December 31st of the year following the year of the Client’s death or to receive distributions under the 5-year rule just like any other Designated Beneficiary. A spouse also has additional options not available to non-spouse beneficiaries. A spouse may elect to “rollover” the Client’s IRA to their own account. Reg. § 1.402(c)-2, Q&A-12(a).

If the spouse is a sole beneficiary, they have the following additional options: they may choose to begin distributions by December 31st of the year in which the Client would have attained the age of 70 $\frac{1}{2}$. Reg. § 1.401(a)(9)-3 Q&A-3(b); they may use the recalculation/fixed-term combination method when calculating their RMDs, Reg. § 1.401(a)(9)-5 Q&A-5(c)(2), that has the advantage of allowing recalculated payouts during spouse’s lifetime but fixed term payouts following her death; and they may elect to treat the Client’s IRA as their own. Reg. § 1.408-8, Q&A-5.

- d. **Multiple Beneficiaries.** In the case of multiple beneficiaries, if any one of the beneficiaries do not qualify as a Designated Beneficiary by the Designation Date then the IRA will be treated as having no Designated Beneficiary. Reg. § 1.401(a)(9)-4, Q&A-3. Consequently, the IRA would be distributed under the 5-year rule. If all of the beneficiaries qualify as Designated Beneficiaries as of the Designation Date, the RMDs must be

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calculated using the oldest Designated Beneficiary's life expectancy. Reg. § 1.401(a)(9)-5, Q&A-7(a). If the beneficiary is a "qualified trust" thus qualifying as a Designated Beneficiary, the RMD must be calculated using the life expectancy of the oldest trust beneficiary. Reg. § 1.401(a)(9)-4, Q&A-5(c) and Reg. § 1.401(a)(9)-5, Q&A-7(a). See section entitled *Separate Account Treatment* for possible post-mortem planning opportunities.

4. **RMD Calculation After Death of Client When Death Was After Client's RBD.** The RMD is calculated in the year of the Client's death as it would have had the Client not died, and any portion of the RMD not distributed before the death of the Client must be distributed to the beneficiary by December 31st of the year of the Client's death. Reg. § 1.401(a)(9)-5, Q&A-4(a).

a. **Beneficiary is Not a Designated Beneficiary.** If the beneficiary is not a Designated Beneficiary, the beneficiary may take a total distribution of the account or may take RMD distributions over a period no longer than the Client's remaining life expectancy in the year of the Client's death, beginning December 31st of the year following the year of the Client's death. Reg. § 1.401(a)(9)-5, Q&A-5(a)(2). The beneficiary would calculate RMDs using the Single Life Table. Reg. § 1.401(a)(9)-5, Q&A-6.

b. **Non-spouse Designated Beneficiary.** If the beneficiary is a non-spouse Designated Beneficiary, all post-death RMDs must begin by December 31st of the year following the year of the Client's death, and the Designated Beneficiary may choose to calculate the RMDs based upon their life expectancy or upon the Client's remaining life expectancy in the year of their death. Reg. § 1.401(a)(9)-5, Q&A-5(a)(1).

Example. Client names Son as the beneficiary of her IRA before dying in 2004 at the age of 75. She did not receive her RMD for 2004, so that distribution, calculated as if she was alive, must be made by December 31, 2004. Son must begin receiving RMDs by December 31, 2005. Those RMDs will be calculated by dividing the IRA balance as of December 31, 2004 by the applicable divisor for Son's age found in the Single Life Table.

c. **Spouse as Designated Beneficiary.** If the Client has selected their spouse as the Designated

Beneficiary, the spouse may choose to begin RMDs by December 31st of the year following the year of the Client's death just like any other Designated Beneficiary. However, if the spouse is the sole beneficiary, they may use the more advantageous recalculation/fixed-term combination method when calculating their RMDs. Reg. § 1.401(a)(9)-5 Q&A-5(c)(2). The spouse also has the option to rollover the IRA to their own IRA. Reg. § 1.402(c)-2, Q&A-12(a). Additionally, if the spouse is the sole Designated Beneficiary, they may elect to treat the Client's IRA as their own. Reg. § 1.408-8, Q&A-5.

d. **Multiple Beneficiaries.** If there are multiple beneficiaries and one or more of the beneficiaries are not a Designated Beneficiary by the Designation Date, the Client is treated as having no beneficiary. Reg. § 1.401(a)(9)-4, Q&A-3. Consequently, the account would need to be distributed over a period no longer than the Client's remaining life expectancy. If all of the multiple beneficiaries do qualify as Designated Beneficiaries, the RMDs may be calculated using the oldest beneficiary's life expectancy or the Client's life expectancy. Reg. § 1.401(a)(9)-5, Q&A-7(a) and Reg. § 1.401(a)(9)-5, Q&A-5(a)(1). If a "qualifying trust" is the Designated Beneficiary, the RMDs may be calculated using the life expectancy of the oldest trust beneficiary or the Client's life expectancy. Reg. § 1.401(a)(9)-5, Q&A-7(a); Reg. § 1.401(a)(9)-4, Q&A-5(c); and Reg. § 1.401(a)(9)-5, Q&A-5(a)(1). See section entitled *Separate Account Treatment* for possible post-mortem planning opportunities.

5. **Separate Account Treatment.** Regardless of whether the Client dies before or after the RBD, in the event that there are multiple Designated Beneficiaries the RMDs will be calculated using the life expectancy of the oldest beneficiary (assuming that the Client's remaining life expectancy is not used for post-RBD Client deaths). However, there is an opportunity for some beneficial post-mortem planning by using the separate account rules. If separate accounts are created for each of the Designated Beneficiaries prior to December 31st of the year following the year of the Client's death, each Designated Beneficiary may calculate RMDs using their own life expectancy. Reg. § 1.401(a)(9)-8, Q&A-2(a). It appears that separate accounts may be created by segregating assets within a single decedent IRA or,

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more simply, by dividing the decedent IRA into separate decedent IRAs for each of the beneficiaries.

The Regulations provide that the separate account rule is only available if the investment gains and losses accruing after the date of death are allocated pro rata among the beneficiary shares. Reg. § 1.401(a)(9)-8, Q&A-3. Therefore, the Client and Planner must provide for calculation of the shares by use of a percentage or fractional formula. Separate account treatment is not available if the shares are determined under a pecuniary formula.

The separate account rules are not available to the beneficiaries of a trust. Reg. § 1.401(a)(9)-4, Q&A-5(c). For example, if a trust is named as beneficiary and the trust agreement provides for distribution of the trust assets equally among three children, the IRA may be divided into three separate decedent IRAs for the benefit of each of the children. However, the RMDs for all three decedent IRAs would be calculated using the life expectancy of the oldest trust beneficiary, and the separate account rules could not be used to allow each child to use their own life expectancy for their decedent IRA.

Announcement of Executive Committee Slate and Chair's Message from page 1

deemed elected at the annual meeting and begin their term of office on October 1, 2005. If other nominations are received for a particular position, a written ballot will be prepared and mailed to all section members by September 1, 2005.

I am going to conclude this message with a mention about communication. Our Section is looking ahead at how we can better communicate with our members and facilitate communication among our members. To that end, pending the WSBA Board of Governors approval and ratification by those attending our annual meeting on September 16th, our Executive Committee added a Communications Chair to the Executive Committee. We have a lot of potential to take what we already have, a website, a list serve, and this newsletter, and make our communication more effective. Please keep this matter in mind. We'll be talking about it at the annual meeting and I hope we move forward in a way that helps our Section better serve its members.

Thank you all for the opportunity to serve as your Chair. It has been a pleasure.

2005 WSBA 50-Year Member Tribute Luncheon

September 29, 2005

The 50-Year Member Tribute Luncheon will be held Wednesday, September 29, at the Sheraton Seattle Hotel & Towers, 1400 Sixth Avenue, Seattle. The reception/registration begins at 11:00 a.m. (no-host bar), and the luncheon/program begins at 12:00 p.m. Registration is \$45 per person. Reservations and payment must be received by September 22, 2005. All members of the legal community are invited. For additional details log on to www.wsba.org or contact the WSBA Service Center at 800-945-WSBA, 206-443-WSBA, or questions@wsba.org.

2005 WSBA Annual Awards Dinner and Business Meeting

September 15, 2005

The WSBA Annual Awards Dinner and Business Meeting will be held Thursday, September 15, at the Fairmont Olympic Hotel, 411 University Street, Seattle. The reception begins at 5:30 p.m. (no-host bar), and the dinner/program begins at 6:30 p.m. Registration is \$75 per person. Reservations and payment must be received no later than September 8, 2005. All members of the legal community are invited to attend. For additional details log on to www.wsba.org or contact the WSBA Service Center at 800-945-WSBA, 206-443-WSBA, or questions@wsba.org.

*This is a publication of a section of the Washington State Bar Association.
All opinions and comments in this publication represent the views of the authors and do not necessarily have the endorsement of the Association or its officers or agents.*

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There are more than 600 members of this section. The officers of the Elder Law Section invite you to become an active member of this important section. All active members of the Washington State Bar Association are eligible. Join today!

- Please enroll me as an active member.
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